Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13072

5 - SUMMARIES

[redacted]

PATIENT NAME: [redacted]
MEDICAL RECORD #:
ADMISSION DATE: 08/20/98
DISCHARGE DATE: 08/31/98
ATTENDING PHYSICIAN: [redacted] M.D.

DISCHARGE SUMMARY

DOB: 08/06/83

BEHAVIOR AND ATTITUDE:
She spoke quietly, but she appeared to be quite angry and depressed.

CHIEF COMPLAINT:
"Mood swings."

JUSTIFICATION FOR HOSPITAL ADMISSION:
She punched a brick wall with her fist for the third time, causing abrasions of her knuckles. This happened on the day of this hospitalization. She had broken fingers from the previous episode of hitting the wall within the past few months. She was reluctant to state whether or not she was still feeling suicidal. She had cut her wrist at least one time during the past year. She still has a three inch long scar from this. She claims that she told no one about this and wore long sleeves to hide it.

HISTORY OF PRESENT ILLNESS:
About one and one half years ago, she began having wide mood swings of excessive anger and sadness. This is around the time when a close friend committed suicide. She had known him since the first grade. Apparently the motivation for this suicide had nothing to do with [redacted] however, so she did not blame herself for it. However, she was very grief stricken. She sometimes was truant from school and got into fights, so she was suspended often enough to fail the ninth grade during the last academic year. She also had difficulty with mental concentration during the past one year while the mood swings were so severe. Her school grades had been fine during the other years before that. In addition to her wide mood swings of sadness and anger caused by the events mentioned above, she also was very angry because she claimed that her father had hit her with his fist on more than one occasion. As recently as about seven weeks ago, she had been bruised by him and given a black eye, as well as some hemorrhage of the "white" of her eyeball. She claimed that her father had hit her with his fist. She said that his temper outbursts were episodically worse, for periods lasting between two and seven days. She said that her own mood swings were much like his in this regard.

PAST HISTORY OF PSYCHIATRIC PROBLEMS:
She previously had tried taking Adderall 10 mg each morning. She said that this caused shaking and made her moods worse. It was stopped a long time ago. More recently, she was taking Prozac 20 mg daily. She says that it did not cause any results which were

DISCHARGE SUMMARY

either better or worse. The Prozac was stopped about one week ago, with no significant change in her mood for the worse or for the better, ever since then.

PAST MEDICAL HISTORY:

She denied having any significant illnesses, injuries, allergies or operations in the past, except for the finger fractures and the wrist laceration, which was self-induced.

PSYCHOSOCIAL HISTORY:

She has grown up with both of her parents. She said that they both are strict and used to be police officers. They have been married for 18 years. [redacted] father travels in his job inspecting homes for the government regarding insurance claims. He is self-employed. [redacted] mother also has changed careers and now is a teacher. They live together with her and her two year old sister[redacted] [redacted] says she has enough friends but she angrily says that her parents do not think her friends are "decent enough" because of the clothes they wear. [redacted] denied any significant legal problems or substance abuse problems.

FAMILY HISTORY:

The patient's father has episodic hot temper outbursts. [redacted] denies any significant legal problems or any significant problems with substance abuse. Maternal uncle has severe psychiatric problem [redacted]

SUBSTANCE ABUSE HISTORY AND LEGAL HISTORY:

She did not reveal any substance abuse history or any legal problems.

MENTAL STATUS EXAMINATION:

She was somewhat evasive about whether she still felt suicidal, but she clearly acknowledged that she had been suicidal at times in the past, during which she was somewhat evasive and was unclear whether she still felt suicidal. She was somewhat depressed and irritable. She listed various things she was dissatisfied about. She was oriented to the correct person, place and time. Her intelligence appeared to be at least average, based on her previous school performance for the past one year and also based on her general fund of knowledge, grammar and vocabulary and her previous work history. Her memory appeared to be adequate, as she was able to recall 3/3 items five minutes later. Attention span appeared adequate.

STRENGTHS:

She has independent thinking and determination.

DIAGNOSTIC IMPRESSION:

AXIS I: Cyclothymia.
Post traumatic stress disorder (violence by her

DISCHARGE SUMMARY

father and the suicide of her friend).
AXIS II: No diagnosis.
AXIS III: No diagnosis.
AXIS IV: Severe.
AXIS V: GAF 40 on admission.

LABORATORY/DIAGNOSTIC FINDINGS:

X-ray of the right hand showed no fracture on 08/28/98. Urine drug screen was negative. Routine urinalysis normal. Urine pregnancy test was negative. Serum electrolytes were normal except for borderline low glucose of 62. Chemical profile including liver enzymes were normal. Thyroid profile including TSH normal. CBC normal.

HOSPITAL COURSE:

She was begun on Depakote Sprinkle 125 mg one after lunch and three after supper. She was advised about an anti-hypoglycemia diet and how to follow it. She was given Nicoderm 14 mg patch daily because of strong cravings for cigarettes, which are not permitted in the hospital. She also took Midrin two tablets PRN migraine headaches followed by one q. 3 hours up to a maximum of five tablets in 24 hours. She angrily hit the wall during a confrontation at the hospital on 08/27, so she was x-rayed with a normal result, even though her hand was somewhat swollen and tender in the area of the fifth metacarpal. Her mood swings partly reduced throughout the hospitalization. She did have one migraine headache with nausea and blurred vision in spite of Depakote, although the Depakote had not been given enough time to fully start taking effect when the migraine occurred. Because of the migraines and her persistent labile moods which had only partly improved, her Depakote dose was increased on 09/01/98, after a serum level was drawn. The increased dose was 125 mg one q. a.m. and four after supper. (125 mg more than her previous daily dose). During the hospitalization, she had repeatedly said that she was convinced that she was going to lose her temper if she had gone home during those days. She also said that she was convinced that after she lost her temper, her father might hit her. She cried and asked for more medication just before the dose was increased on 09/01/98. She developed an unusually close relationship with another female patient on the unit, involving hitting each other on the buttocks with a book on one occasion. When staff tried to re-direct her about this type of behavior, she became angry.

CONDITION ON DISCHARGE:

She said that her mood swings were considerably improved by the time of discharge, even though she still needs some more improvement of them in the future. She claimed that she was going to try to cooperate better with her family and that she would avoid any risk of suicide or violence to other people or property. It is unclear about what type of relationship she intends to have in the

[redacted]

DISCHARGE SUMMARY

future with the girl she became very close to in the hospital.

POST HOSPITAL CARE PLANS:
1) Outpatient psychiatric follow up by Dr. [redacted] on 09/01/98 at 04:00 p.m. [redacted].
2) She will live at home and return to her regular school.
3) Anti-hypoglycemia diet.
4) Activity as tolerated.
5) Discharge medications - Depakote Sprinkle 125 mg one after breakfast and four after supper daily.

PROGNOSIS:
Good, if she cooperates with treatment but poor if she does not.

FINAL DIAGNOSIS:

AXIS I:	Cyclothymia.
	Post traumatic stress disorder.
AXIS II:	No diagnosis.
AXIS III:	Hypoglycemia.
AXIS IV:	Severe.
AXIS V:	GAF 40 on admission.
	GAF 50 on discharge.

[redacted] M.D.

[redacted] M.D.

[redacted]
D: 09/06/98
T: 09/10/98
[redacted]

cc: Dr. [redacted]

CC # EDR-2789
CFSAN Project # 13072
11/23/98 EJB
[redacted]
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[redacted]

PATIENT NAME: [redacted]
MEDICAL RECORD #:
ADMISSION DATE: 08/20/98
ATTENDING PHYSICIAN: [redacted] M.D.

PSYCHIATRIC ASSESSMENT

DOB: [redacted]

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PSYCHIATRIC ASSESSMENT

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AXIS I: Cyclothymia.
Post traumatic stress disorder (violence by her father and the suicide of her friend).

[redacted]

PATIENT NAME:
MEDICAL RECORD #: [redacted]

PSYCHIATRIC ASSESSMENT

AXIS II: No diagnosis.
AXIS III: No diagnosis.
AXIS IV: Severe.
AXIS V: GAF 40 on admission.

ESTIMATED LENGTH OF STAY:
Between five and eight days.

INITIAL TREATMENT PLAN:
1) Start Depakote for the patient and maybe later for father.
2) Family therapy.

DISCHARGE CRITERIA:
1) Avoidance of self-destructive behavior and also avoidance of situations which cause fighting.

[redacted] M.D.

[redacted] M.D.

[redacted]
D: 08/22/98
T: 08/22/98
[redacted]

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11/23/98 EJB [redacted]
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